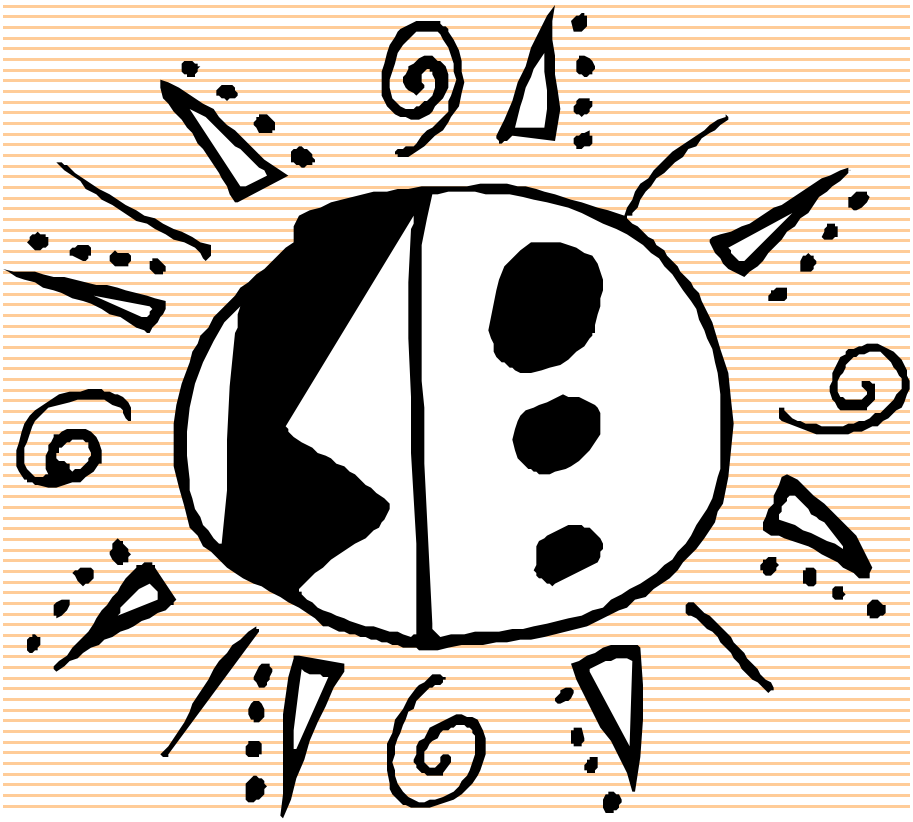


Chapter 2
Cultural Perspectives On Health And Evaluation

How Do We Develop Cultural Perspectives On Health And Evaluation?

A Conversation of CENTERED Project's Blue Ribbon Panel, August 2000

Christine Lowery, PhD

University of Wisconsin

I'm a visual person and most members of my community are visual people. The Navajo rug tells a story through its color and its symbols. As a community, you would understand the story the rug tells: you would know where you are; you would have a visual picture of where you need to go. Then you can ask the questions.

This is where the conflict starts. It is very difficult to translate this concept into evaluation terms. I don't know how to say this in English, but if I could see it, I would know what it was. How do you translate that into action steps, because action steps don't even belong here? That is the cultural difficulty. I know what I can see, and I can recognize it when communities are making progress.

The picture in the rug is not a geographic location. There is something in there about the maker of the rug, it's telling about a time period, but all of that is embedded. If you don't have that understanding, you don't know what is going on. But if you can see yourself as part of it, and this is where the community comes in, the spirituality of community is that each piece can contain your knowledge, and you are part of that story. And that is where the talk comes in. Each of you can see yourself in that picture or in that landscape. You bring your own version of that story, and you put it together. It's like laying a feast on the table.

Quinton Baker
Community Health, Leadership and Development

I think that to do it, you have to get out of our box of dealing with written words and linear thinking and you have to do story or music or something. You have to do something visually or orally, because most of the communities that we are talking about, communicate through oral or visual mains. They don't do a lot of writing for communicating their lives.

Ross F. Conner, PhD
University of California, Irvine

We've got to introduce the holistic perspective right off, by validating the community views, so the communities will be able to resonate. Then we can move to tools and all these other things. It's not taking that story and making it fit an academic model. Instead, it is making that story the center. The other evaluation things are brought in as needed.

Bobby Milstein, MPH
Centers for Disease Control and Prevention (CDC)

You can't convince other people to give resources to build community capacity, unless you can show where you are, and where you need to go. If it matters, you can measure it. The problem is, that until you formalize something culturally, you can't translate it to another culture. So, I believe that building a Navajo rug is great to clarify for the maker, what message they want to give, and to use the cultural symbols that are appropriate in their own culture, but when we approach cross-cultural communication, there is another challenge there. Here, we are talking about multiple forms of cross-culture communication fitting into a required formalism that has to turn into some kind of quantification and systematic tracking. If you can't link the investments to changes in disparities, at some point it is going to be like a house of cards, it is going to fall down.

Christine Lowery, PhD

University of Wisconsin

I think this is what we have to challenge in this, because we have an opportunity to challenge the required formalism. We're not saying, "do away with the formalism," we're just saying, "open it up."

Paula M. Lantz, PhD
University of Michigan School of Public Health

I want to throw something on the table that I think is an absolute of doing any kind of evaluation. Take any intervention, program, policy, or service, get a group of people who care about that, and ask them to think about,

"what are the things that you want to know in an evaluation?" You can brainstorm and come up with dozens and dozens and dozens of things that potentially could be looked at. We could cover a whole wall with questions we might ask about one specific intervention in one community. So, something that we're going to have to grapple with, is the messy reality that different groups of people are going to be interested in different questions.

Now historically, the researchers and academics had been given the power to do the evaluations, and they had their own set of questions that they prioritized, and they've looked at, and that is what has emerged as being the knowledge that we want to produce about the evaluation. When you allow more people voice and power in determining those questions, you're going to get other things that rise and are of interest, as well. We have this big picture, this Navajo rug. We could construct this beautiful story about an intervention. When you let the researchers ask their traditional questions, they might just ask about two of the diamonds in the middle of the pattern. That is all they are going to focus on.

What you really want to do, is say, "How are we going to tell this holistic, whole story about it?" It is going to be really challenging to get there. Different people are going to have different questions, and no one is going to have the time, energy or resources to answer every question about it. How do you get all those voices in the mix at the beginning?

Don Goodwin, MS, DrPH
SC Department of Health and Environmental Control

We need a way of communicating that is effective and appreciated by that community. It doesn't matter if it is a rug or a song or a dance or a painting, whatever it happens to be. You want to find that system and be open to non-traditional systems of delivery of care. The point of evaluation is whether your desired outcome is occurring, whatever that system happens to be.

I was in one village where the United Nations was doing an assessment. They went down a checklist. They were counting wells. They put out money for wells, they hadn't been back in a year, and they're going around checking the wells. They went out and checked outhouses, counted them, crediting the agency, "UNICEF paid for this." All you had to do was look at the demeanor of the people. There was total depression. And, I'm watching, and I finally took the people aside and said, "What is going on?" And they said, "We're moving. The government has ordered this community to move." So, all those wells, all those outhouses, they're going to be left behind. There is nothing that is going to be here. I went over and I talked to the leader of this UN mission. She was here for one day, looking at the village, and moving on to the next. When I asked her a question about where the village is going to be in three months, she finally asked the translator, "Where are you going to be?"

"Well, we're not going to be here."

"Now, just a minute. We've been counting and evaluating. What do you mean, you're not going to be here?"

Nobody had asked the people, "What are your priority needs?" The UN went in with its assumptions, these are the things you need: you need water - we build wells; you need outhouses; etc. Nobody asked about what was most relevant to them – the fact that they were being forced to leave their lands and were going to lose everything, the least of which were the UN's wells and outhouses. When the local military general was asked about this "move", he confirmed that it had been in the planning for a couple

of years, but that no one from the UN had asked for his input on their work. The evaluation mission to that village was aborted.

Clearly, if you are an outsider, you must first learn to listen and ask questions, then work with the community to use your expertise to assist in addressing the priority needs as the community defines them.

Quinton Baker
Community Health, Leadership and Development

You can be legitimized if you are from outside when you can use the tools that are in the community. Part of the cross-cultural thing is not changing the community to fit into a different culture, but being able to understand how they function in that culture. When the outside researcher or evaluator can use the tools of the community, then there is a legitimacy that automatically comes with that.

Bobby Milstein, MPH

Centers for Disease Control and Prevention (CDC)

Evaluation is always going to be interactive. The minute that you have interaction among cultures, there are insiders and outsiders. We are going to have to deal with that issue of perspectives and interactions. That is fundamental. We have different languages or symbol systems. Somebody would represent this rug, and it would make a lot of sense internally in that culture, but it would need to be translated to others in a different symbol set. We are in a certain status, a place, a location, and we want to move to another location. Getting to a system of values is the hardest part of evaluation.

Johnnie Bell Bunch, BS, MS, RN
Hampton University School of Nursing

From a health perspective and as a health care provider, I would start at health. I wouldn't look at their disease and sickness because we are trying to move along the continuum from that illness to that wellness perspective. The goal is to promote healthy communities, so I would not introduce the concept of disease and sickness. I would start with the strengths. What is in that culture that allows some people to live long, healthy lives?

Christine Lowery, PhD

University of Wisconsin

So, the picture you want to draw, the rug you want to weave, is a healthy community, with healthy members of the community. They can do certain things; they do things certain ways. The valued male member in Native American society pays his village dues; he attends his village meetings; he participates in community work, and is

called upon to do so; he supports his family. Those are all positive. And that is a measure of a healthy man.

Actually, it is a statement about who is a valued community member, because that is health. I am a community member and I contribute. This is how I contribute. This is how I behave. Physical health is just one segment of health and well-being. It doesn't matter as much in some communities, as what you contribute. For example, in my Native American culture, you could be on dialysis. You could go Monday, Wednesday and Friday, but the other days, you are participating in your community and you're considered a healthy person. Your contribution to the collective is what is considered the sign of health. You do everything you are supposed to do in village life, even though you go to dialysis three times a week.

Bobby Milstein, MPH

Centers for Disease Control and Prevention (CDC)

Nobody sees the dialysis as a bad thing?

Christine Lowery, PhD

University of Wisconsin

That is part of the issue with diabetes: it is not seen as a bad thing, it is seen as something that has happened to you but you are still contributing, so it is not disease.

Bobby Milstein, MPH

Centers for Disease Control and Prevention (CDC)

Except that you're going to die earlier than you should have, and the community is now denied your contributions after that. There are years of potential life that the community doesn't have.

Christine Lowery, PhD

University of Wisconsin

This is the difference in cultural thinking. You cannot think in those terms. A person does not come to be here for long: he is just here on earth for this length of time, and that is it. And when he goes, he goes. We're not into prolonging life. We live our life for today. These are the things that we have to do, these are the contributions I can give today. You have to shift the way you think of health and health prevention into that cultural context.

Quinton Baker, MPH
Community Health, Leadership and Development

One thing that I have to deal with, in particular with diabetes, is the notion that, "God gave me this disease. If God wants to heal me, he will." All of this fuss that you're doing takes away from that relationship with God. And that is a very strong cultural piece in the African-American community.

You're going to have to take prevention and make it a part of God's plan. You can't say, "We have medicine and we have this and we can do that." Diabetes is rampant in the African-American community. It is so prevalent that people think it is a natural part of growing old. It's not as much of an issue within the confines of the culture as it is

outside the culture. A lot of ministers don't talk about their illnesses because it denotes that they don't live right. Illness is something that happens because you're not doing something right.

There are a lot of cultural factors that we don't factor in when we take the biomedical model or the health promotion model and look at various cultures. We don't think about what is really at play there in the culture. You have to recognize and accept how the culture looks at health, illness, and well-being, and what are principle values within the culture. You have to look at it without the judgement piece - "This is bad."

Bobby Milstein, MPH

Centers for Disease Control and Prevention (CDC)

But, you're not saying that diabetes is ever a good thing, are you?

Quinton Baker
Community Health, Leadership and Development

It's not good or bad. The fact that both my parents were diabetic and that three of their children lived with the disease, is just an accepted thing. No one made any big fuss. When I was growing up, people had "sugar." It wasn't an issue, "Oh how dreadful, we've got to do something about this." It was, "Well, honey, my sugar is acting up a little today." You've got to understand that before you can even begin to think about how to reduce diabetes in that culture. You've got to understand the way that culture looks at diabetes.

Belinda Reininger, DrPH
University of Texas-Houston

School of Public Health at Brownsville

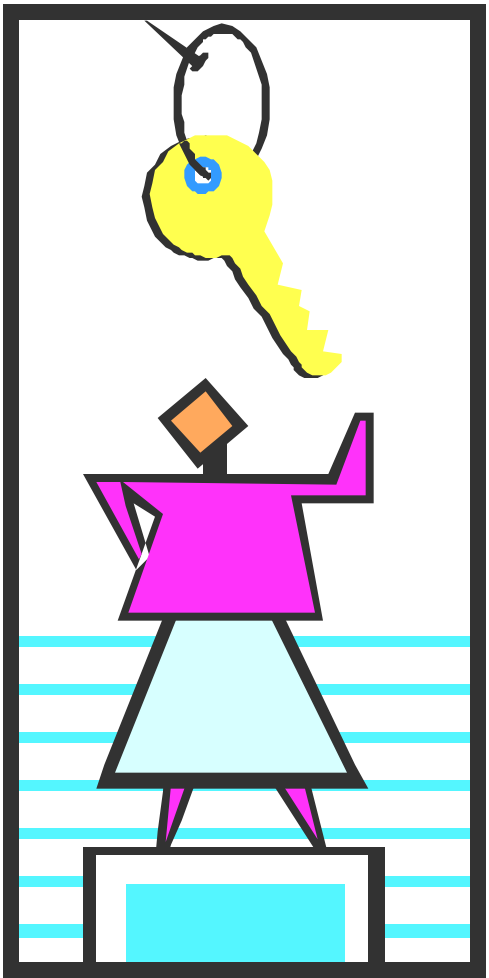
Part of what we want to send as a message is that evaluators better learn how to talk with their community within the community's cultural framework for any particular issue.

Christine Lowery, PhD
University of Wisconsin

If you don't listen, forget it. You shouldn't even go in talking.

Quinton Baker
Community Health, Leadership and Development

If you don't understand what Christine pointed out earlier about her culture and the way in which they look at life, death and health, what kind of indicators or measures are you going to use? What kinds of interventions are you going to be talking about? I think one of the clear messages we want to say to evaluators is, you can't come into a culture and impose a framework without really getting to the root of how the culture looks at the issues.



Cultural Perspectives On Health: Listen To The Stories

Pauline Brooks, PhD
California Endowment

Evaluation is operating in the space where two or more worlds meet: cultural, programmatic, financial, and scientific. The task is to find meaning for all involved.
What necessitates a trip to the doctor for treatment or prevention may vary culturally. If you come from another country, you may not see preventive or routine checkups as important, or may see treatments such as pills and surgery as negative. People may be reluctant to address or acknowledge illness; acknowledging it, naming it, may give the illness undesired strength.

Evaluation Challenges

Just counting the number of visits is not enough. The patient may not perceive the visit as helpful especially if there's miscommunication, even if both caregiver and patient are speaking the same language. A doctor visit doesn't indicate that a patient is on the way to getting better. With parallel treatments happening, one major challenge is knowing what it was that really helped the patient to get better---was it the doctor's treatment or the indigenous medicine or therapy? Or both? For some indigenous cultures, traditional medicines and therapies may be used but not talked about with people who are outside of the culture. How do we know what was actually done for prevention or treatment?

How do you evaluate treatment for an illness if there's a cultural stigma around talking about it, for example: mental health? What would indicate the success of a mental health program in such a community? How do we clearly demarcate where a community starts in order to measure how far a community has come? What happens when the distance between start and finish is not linear? How do we approach evaluation from a holistic perspective, respecting and understanding how cultures operate?

Even if the doctor explains treatment and all are speaking the same language, how do we know what the patient is really understanding or believing? Does the patient really believe and trust that the doctor is telling the whole truth? Does the patient really believe that health happens the way that the doctor is saying? What implications does this have for the patient in following the regimen exactly how the doctor has prescribed it? How do we capture what people actually do and their state of mind when they are doing it? These may be very different from what people tell us they did. How do you evaluate prayer as a medicine and the effects of prayer or spiritual healing, and the manipulation of positive and negative energy as prevention or treatment? Mixed into the above are history, the existence and manifestations of racism throughout the society and its institutions, socioeconomic status, acculturation, education, and habits and traditions. The challenge for evaluation becomes one of figuring out which, if any, of these factors significantly bear on the processes that result in racial and ethnic disparities in health.

"Communities have natural ways of telling their stories about what health means, about what the journey is all about, and evaluators need to be more skilled in recognizing those stories."

Doug Easterling, PhD
University of North Carolina at Greensboro

From A Mexican American
Bad Air

During the time a woman is pregnant, there is a lot of care that takes place. There are times that midwives come to your house if you can't afford to go to the doctor's office. *Parteras* is what they are called. They can also be called during the delivery of the child. Generally we are taught that after we give birth there is a 40day *quarentara* which is a quarantine of specifically not being able to go outside, being "bedridden." Food is brought to the bed. Basically, all your household chores are done by someone else – taking care of the husband, feeding the family, washing the clothes. The theory is that the pores are open and the body can receive air causing hemorrhaging, headaches, inflammation, or muscle spasms. So, basically, the new mother is covered head to toe just to avoid possibly getting sick because that's supposed to be a very weak time that a woman is going through.

It's the fear of contaminating air and of how this air gets into, sucked into, your pores and causes your body to get inflammation, causing the body to sort of puff. At least my mom has told me this. Having been pregnant and not taking care of myself the way culturally I should of, my mom believes that's what happened to me and that's why I have not been able to lose some of the weight that I have gained. She says "*tienes aire, tienes aire*, you have air, you have air."

I am going to a holistic healer for massage therapy. He says that my arms have air pockets and other parts of my body, too. So, he says that I have to keep going back to release the air from my arms and other parts of my body. But, basically I need to have that pulled out, so that the energy releases and goes where it needs to go and blood starts to flow more. It is amazing because this is something my mom has told me, that my body after I had my son received a lot of air because I did not take care of myself.

A week after I had my son, I had to go out; I had business. It was cold, and I didn't have anything covering my head, didn't have anything covering my arms. I think I wore shorts to the Department of Motor Vehicles and I really didn't take care of myself. I cooked the week after that and that is something that you are not supposed to be doing. So my body has received cold air, as well as hot air. Because my pores were open, the air has come into my body and it gets locked into certain areas. The healer is Filipino. I'm not going to say that he is a doctor; he is a therapist. He is not a chiropractor, but he has his own business of a massaging, healing type of therapy. So I thought that was pretty fascinating. If it's true or not, I don't know what to say, but when you hear that two stories coincide, it starts to make you think that maybe mom is right. Maybe mom knows more than I want to give her credit for. And my mom is from Mexico, but she came to the States at a very early age, so she brought that along with her.

Question: Will you do something similar with your children?
I believe so; there are certain things that don't hurt to keep with you. The values.

Herbs

I know that herbs and teas are very, very common. How my mom used to use cactus, she would boil it and the water that came from that she would drink. She said that she felt better. Instead of taking the doctor's pill, she would drink that and that would make her feel better. Sometimes, she would make herself a "cactus salad" that also made her feel better. Eating lots of *apio*, which is celery, is a remedy that she used to use. For stomach pains, generally you do not go to the doctor. For a stomachache, you will drink some tea and also massage the stomach to heal some of the pain. *Yerba Buena* or *manzanilla*, which are chamomile or spearmint teas, are good for soothing the stomach. Herbs play a big part in the culture. When someone is very nervous, there is a plant called "*ruda*" which is supposed to help you calm your nerves. We always want to stay away from taking pills. If we can stay away from pills, we will do it.

Spells

My ex-mother-in-law told me a story of her mother-in-law, who before she died, began to spit mucus. She described it as moldy. Two weeks before she died they took her to a spiritual healer. He said that someone had cast a spell on her. The immediate family took her to the hospital for tests; the doctors concluded that there was nothing wrong with her. Although the doctors said this, she was not getting better. She was getting worse rapidly. If you are in extreme pain or you have a growth, those are certain circumstances that you may consider that someone has done something against you. It's something that is very common. Some people believe that witchcraft is very commonly practiced.

If someone cast a spell on you, it is seen that you are weak spiritually; maybe you don't have faith. If you believe in those things, then you are less prone to be affected.

If you do have a strong belief and say a person has a possession of yours, an undergarment or something, and they get a hold of that, it is believed that, they can do something to you by just having that possession. But usually it is because you are a weaker being.

Miscommunication

In my community, going to the doctor isn't always helpful. It all depends on how the doctor approaches the patient. Sometimes the patients themselves won't speak and they don't think the treatment is going to do any harm. But in some cases, for example, cancer patients who go through chemotherapy, they think it's bad against their body. It's going to affect them more than what the doctor chooses to tell them. There are times when it is seen as more than what it is, that it affects you more than what the doctor is willing to tell you. So there is a lot of skepticism in believing in what the doctors are really saying or that they are telling you the truth about the treatments that they are giving you.

Question: Why would there be that skepticism? Where do you think it comes from?
Because they don't feel better. I can just tell you an example. My mom goes to the doctors constantly and she feels like the doctor doesn't pay enough attention. She says, "The doctor is not listening to what I am saying because I am telling this hurts and he gives me another medication, but it makes me feel worse or something else hurts." I think this happens a lot, where the doctor doesn't listen to the patient. Instead of building confidence and being comfortable to tell the doctor what's really wrong with them, instead they are going to shut down even more. And if the patient doesn't know how to speak well or explain what's happening, it causes the miscommunications.

Question: Why would anybody go to a medical doctor?
They might go to a doctor for quick fixes. Possibly, they would go just to know that they have gone to different resources. They will fluctuate because they want to know, "Okay, am I really sick or is it because someone has done me some harm?" The quick fixes are sometimes just popping the pills and sometimes going to find out that something else is wrong with me. I'm not getting better from his medicine so I'll go to the *curanderas* to see if she can tell me something different. And that is what also causes people to go to Tijuana, because they would rather go to Mexico to get medicine instead of here. That sometimes causes them to get bad side effects and not to get better.

Getting Medicine

A lot depends on accessing medicine. Like going over the Mexico border to get over the counter medicine, where here you would need a prescription. When I was in Carlsbad, I had a sore throat. I was looking for this lozenge that you suck on and instantly your sore throat is fine. Rosalinda took me to a Mexican market and this woman had this tablet called *Ahin*, it's a very strong cure for a sore throat. You would have to have a prescription here.

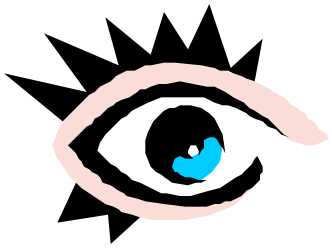
So this lady pulls out this box and it was like doing a drug deal, but it is safe. I bought ten pills. I took them and my sore throat was gone right away. Even insulin syringes, you can just go to a market and get it. If you know where to go, you can get what you need.

Prayer

My mom told me that in her country the population believes a lot in saints. There is this one saint, a black saint. She said that a lot of people pray to this saint still today. In the villages and small towns where there is no access to health care, they might have one doctor but the means of getting to that doctor they might not have. They tend to pray and do what is called "*manda*," sort of like a promise to their saint that if he were to cure my son or my child from whatever illness the child might have, you will do good deeds. If it's a serious illness, they would promise to do a certain deed for the rest of days if that miracle were to happen. So I know that they would do that *manda* and they would burn incense around that child and they would hope that a miracle happens. Sometimes they wait until the child is almost close to death before seeking help from a doctor. They will set up sort of a shrine and pray and pray and hope for a miracle.

Evil Eye

My mother had a brother who died when he was child. The thought was that this woman had walked by him and put a curse on him. He was a beautiful blond baby, chubby, full of life – this woman looked at him and spit on him and then he got very sick and died quickly, right after that. They blamed that woman. I don't know if that woman was an outcast or just some crazy woman on the street, but she looked at him and spit on him and he got sick. Who knows, maybe from her saliva he contracted some illness, but that was never even brought up. The funny thing is that I was walking down the street this weekend, shopping with a friend and this elderly lady was walking towards me with her family and she looked at me and gave me this really dirty look. Even though I don't believe in this sort of thing, my girlfriend said, "Oh look she is giving you the evil eye." And I freaked – just because I've heard stories and so you tend to believe it.



From A Korean American

Dying At Home

I remember when my uncle passed away. When he was nearing his last few days, he would not go to the hospital. In his Buddhist culture, where you die is where your spirit will reside. It is important to decide while you are still alive. People want to live their last few days at home because where they die is where their spirit resides and so you want the person to pass away at home, not in the hospital.

Mental Health

In Korea if you have a mental problem, you don't seek help, and family members will be in denial. If it's really serious they will try to keep you away from society so that no one will ever discover it. To discover that someone in your family has mental illness, then it's in your blood and no one will marry you.

I think that's true for deformities too, even if you are perfectly functional. You have to spend the rest of your life away from people. It's not very acceptable. Retardation is like that also. Everything that is abnormal, it's not understood. The belief is that something is wrong with your blood. When you are about to marry someone, there are a lot of questions that are asked. It's like filling out a medical questionnaire.

Health And Happiness

If you raise a family of healthy children with healthy marriages and healthy grandchildren, you are considered healthy. If you have a happy family, then they are mentally stable. Your children are sort of an indication of how your family is.

Question: So if I was in the Korean culture and I had two children that were sickly, and my husband I really didn't get a long very well, would that mean that I was not healthy?
Yeah – I think people would question your blood, also something's not spiritually right, you are not raising your children right and if your relationship with your husband is not good, then your balance is not right.

Question: Would the definition of a healthy woman be different from a healthy man?
I think so. I think it would do with your ability to bear healthy children. Whatever happens to your child, illness, disease, sex, is usually blamed on the woman.

From A Taiwanese American

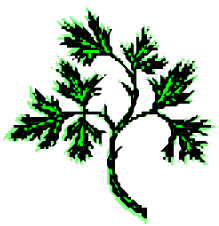
Medicine

In Taiwan, the little kids go to the doctor all the time. They have clinics. There are no appointments, you just walk in and the doctors have medicine right there. The healthcare system is so different there, usually neighborhood clinics. They do go to get shots, immunizations. People are aware of immunizations now. My pediatrician when I was growing up was just down the street. There was no institution where you had to make an appointment. He's just down the street. He knows every kid and we know where he lives.

From A Taiwanese And A Mainland Chinese American

Comparisons

Taiwanese: A lot of times I think the Chinese culture believes that with herbal medicines, as long as you have sort of a peaceful coexistence with this illness in your effort to manage it, then that's okay. A lot of times when you go to an acupuncturist it is about maintaining your condition; it isn't about curing your disease because sometimes you can't really cure



everybody. Even if you are recovering from heart disease it's mostly about the balance and condition of your body over all and how you use herbs to adjust that kind of balance. And that makes you able to work and function.

Mainland Chinese: But they do want to get a cure. Their cure is to also try traditional medicine, rather than go to Western medicine. Sometimes, when it involves surgery, they try everything possible rather than go through that. Unless it's absolutely a must, there is no cure and you are going to die, then they'll go under the knife.

Taiwanese: The other thing is that we still go to traditional medicine doctors if it's not something that is acute. If I have a really bad flu, then I go to a Western doctor, but if I have really bad cramps, my mom goes and seeks out this traditional medicine guy and then you get these herbs and you cook them and drink that. It was not urgent. We would never go to a Western doctor for anything like that.

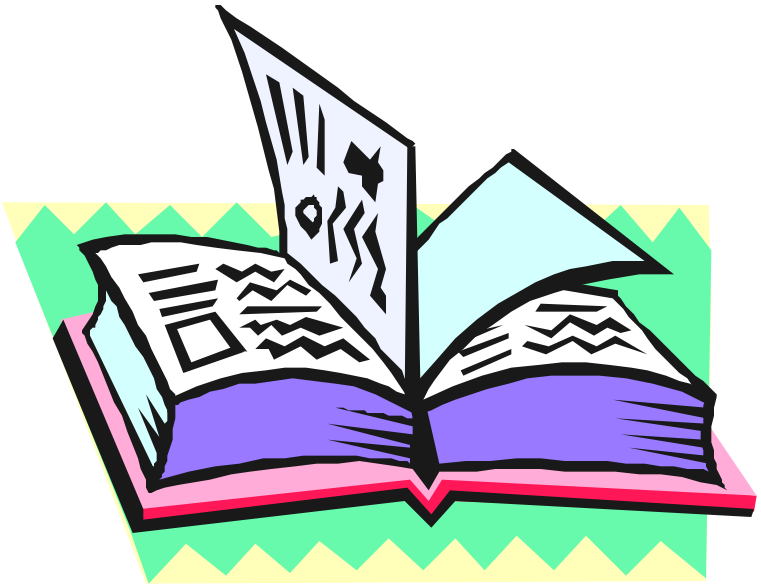
From An African American

Stereotyping

Growing up in a middle class, multicultural, black household, I was raised to value education, opportunity, cultural events, nature, and I was taught by my maternal grandmother that everything I did reflected my family's name. I had always done well in school and had sometimes been too smart for the teachers. Due to the circumstances of my environment and education, I attended a New England boarding school for high school, dating didn't appear as a real option for me until college.

When I was 15 or 16 though, I will never forget my visit to a new physician. Despite the fact that I was only in for a soccer physical, the physician insisted on talking with me about birth control. I insisted that I wasn't sexually active, but she persisted with talk about condoms and the pill. She even mentioned birth control to my mother and began a conversation about "How all of these young girls lie about sex and most of them are doing it." She failed to understand the role that U.S. cultural silence around sex had on those who were sexually active. Most sexually active youth were unaware of options and consequences of their sexual activity, and had largely been failed by our medical and education systems. And she failed to remember that "most" of the adolescents she referred to in her paradigm, still left a few who were not sexually active. Based on appearances, one might have thought that this African-American, Southern woman would have been less likely to treat me based on a socio-cultural stereotype. Not only on this visit, but on two subsequent visits, this woman refused to believe me and pushed for me to have a pelvic exam. I did not have the exam and suggested that the doctor not treat all clients with a certain skin color that way. My mother and I filed a complaint with her, and found another physician: this time an Afro-Caribbean woman who remained my physician through college. Most of my school peers were white, Anglo-Saxon, protestant, upper-middle class to upper class, and unbelievably sexually active to me. I offered the few words of wisdom I gained about birth control to them, since I was sure their physicians never mentioned it.

As a woman of African descent living in the United States, the health care system has perceived me as a health problem waiting to happen. Without ever asking me about my diet, family history or customs, it has been presumed that I'm at risk for teenage pregnancy, substance abuse, high blood pressure, etc. I come from several generations of health providers and researchers. Most "black" foods haven't been a part of my family's diet. Two out of four of my grandparents hail from different countries. I have a cousin whose Thalessemia diagnosis was missed several times. Why? Race and color are poor proxies for culture, genes and or socioeconomic status more often than we think. Most of what culture influences is not visible to the naked eye: values, roles, diet, customs, traditions, spiritual and religious beliefs, history, education, exposure, acculturation, language, social and political identities, etc.



What Do The Stories Tell Us About Health And Evaluation?

A Conversation Of The CENTERED Project's Blue Ribbon Panel

Christine Lowery, PhD
University of Wisconsin at Milwaukee

There is no one, right way to do evaluation: there has to be many pathways. How do you help communities define the health landscape for themselves, in cultural ways? And then, how do you evaluate that, because the problem and the evaluation are so closely intertwined, that you can't do one without the other?

I will give you an example that I thought about yesterday. It is this whole idea about identifying culturally this issue of diabetes. If, in fact, we are going to do a cultural landscape of diabetes, one of the ways that you would do it in one of the villages on the Laguna reservation is by using genograms. Who, in clan groups, has diabetes? You would do it inter-generationally, so you would identify grandmothers who have died from diabetes. This is one pictorial way of demonstrating the impact of diabetes collectively on a clan group. You would draw that out, and you would talk about the implications of all of these deaths collectively, because our Tribal groups don't think in terms of individuals.

The concept of living a long life is a dominant cultural value. Our Indian value is living a good life, which is totally different. It has nothing to do with length. It is a good life. But, if you could see the impact of diabetes or heart disease on an entire clan group, then you

can see collectively how much we are losing. Then that clan group becomes responsible for helping each other change individual behaviors. They do it in a collective way, inter-generationally, with grandmothers and grandchildren, because grandmothers want their grandchildren to be happy and healthy and have the opportunity for living a good life.

Communities can already do this. They may not have that missing tool which is a genogram. That is what I think we need to provide: to show communities the different tools that they can use to represent, in their own ways, what their pictures of health and disease look like. That helps them find the pathways to what they need to do to address these issues on their own, and evaluate their progress.

I think, from a cultural perspective, the types of tools that we want to use are those tools that really help communities see their own picture of their health and their lives and what they can do about it. Those would be the most useful tools.

Pauline E. Brooks, PhD
The California Endowment

Well, suppose I am sent out to your community to do an evaluation. What I understand is that an evaluator that comes out to your community needs to sit still and listen. They are going to need to be there for a while and be guided into that community, and then figure out what they could offer and what they couldn't offer. The evaluator is going to have to take the time to understand the community.

Ross Conner, PhD
University of California, Irvine

Participatory evaluation is really common now. All the evaluators are talking about it in their meeting this year. They think it's in their tool bag, but what they need is a whole different conceptualization: that this person who has diabetes is fine. That is very different. And the only way to tell that is through a story that shows how the culture gives meaning and defines what health and illness are. That is the insight that all of us got.

Bobby Milstein, MPH

Centers for Disease Control and Prevention (CDC)

I also got a lot out of the diabetes story. What I saw is that there is a very profound difference in how values identification has to happen in a project addressing multi-cultural disparities. Values identification is critical for engaging stakeholders; it is the aim of understanding local values. We need to expand the definition of what counts as data, to include the cultural landscape.

Belinda Reininger, DrPH
University of Texas-Houston School of Public Health at Brownsville

Something that struck me earlier is that everybody is talking about participatory evaluation. Well, certainly not everyone is doing participatory evaluation. As someone who has tried to do participatory evaluation, there are times that I get close, and other times that I'm pretty far from it, even though I'm saying it is participatory evaluation. Perhaps we can propose a descriptive continuum. I'm not trying to place value on that continuum, but certainly you can go through evaluation at a surface level of engaging community versus a very in-depth listening, community-driven way. We're trying to say evaluation needs to be at that deeper level.

Quinton Baker
Community Health, Leadership and Development

What I heard was that we need different indicators for marking what health is, different ways of determining how we judge what is healthy.

Christine Lowery, PhD
University of Wisconsin at Milwaukee

There really has to be some personal changes and understanding at that deeper level, on the part of evaluators. It is not just indicators. It is whole belief systems. It is whole lifestyles. It is the way life is conducted. It is the way one prepares to die. It is so contextual, that the evaluation framework, from my perspective, pales in comparison.

Quinton Baker
Community Health, Leadership and Development

We really have to help people understand that health, as it is defined by the dominant culture, is not necessarily health in the sub-cultures. All of these community programs are going to be evaluated against the dominant culture's standard of what health is. The context of the community's story gives another perspective of what is healthy and what is good.

Jerry Dell Gimarc, MA

South Carolina Turning Points

We know that the current approach to funding, implementing and evaluating community programs isn't working. Unless we understand what is valued, and what is important to the community, all this stuff about exercise and diet, nattering away at people isn't going to make a difference. It hasn't been making any difference. What are the fundamental underlying values that are important for the community? What is going to bring about change that the community wants to see? Because what is imposed from outside is not going to do it.

Christine Lowery, PhD
University of Wisconsin at Milwaukee

Storytelling about illness shows how really complex our cultural differences are, because of where people think ailment comes from. I'm going to give you two examples having to do with the power of ants. That is the Power of ants, A-N-T-S. One of them goes back to my childhood, when my mother killed the queen ant in an ant pile underneath the clothesline in her village. She used a very powerful medicine and killed the ants. For two years, she suffered with a sore that started as a pinpoint on her foot and then broadened to her whole foot. It was oozing for two years, and then she started having really severe earaches. My Laguna grandparents took their Hopi daughter-in-law to a medicine person, and said, "There is something wrong with her. She's been to the doctor off and on for two years. They don't know how to take care of this, and now her earaches are getting really bad." She walks in, and the first thing he asks her, because he is experienced here and he's old enough to be experienced with this kind of ailment is, "What did you do to the ants?" Because she had destroyed their home, they had moved into her foot. He applied a poultice and asked the ants to leave her body within four days. And in four days, it cleared up and went to a small piece, and the scab dropped off. But she had to do certain things to help with the ants, and the ants showed her. One morning, she was coming out of the outhouse and they were moving their colony from one anthill to another. She saw them move their queen and that was the sign that this was okay, that she did what she had to do, she was permitted to see it, and that stopped.

Now, there is an ant pile outside my grandfather's house. It wasn't the original ant pile. It was a pile of gravel into which the ants had moved. The contractor wants to use that gravel pile to throw into the house to raise the floors, and my mother is standing on the ant pile, and says, "No. These are very powerful. These ants have a lot of power. You won't use this gravel." We

had to tell him, and he's a Laguna man, we had to tell him three times. I'm still afraid he's going to use the gravel, but we've done what we're supposed to do. We spread corn meal; my mother has spoken to them in the Hopi language, explaining to them why they have to move. We've drawn the cornmeal trail to an area where they might be safer, but they haven't moved. We don't want him to use the gravel. He understands the power of the ants because he has seen people who have bothered ants go into a medicine man, and he said, "When they rub the feathers on them, gravel from ant hills actually falls off their body and you can see the living ants drop off." That's an even deeper cultural message about how we see we are connected to illness, and I don't know what CDC would do with these kinds of stories. But see, I'm a Native American who happens to be an academic. But my belief system is that I know the power of animals, and ants, and rocks, and wind, and water. I know all of that, and I don't mess with anything.

Bobby Milstein, MPH

Centers for Disease Control and Prevention (CDC)

Just a question, what do you make out of that story relative to evaluation? What would we do with such a story? What lesson could be drawn from that story relative to the task of doing a better job of evaluating programs that are working on disease within that community?

Pauline E. Brooks, PhD
The California Endowment

For evaluation, the story may be the beginning place for the evaluator to understand something more about the community. It might be figuring out where things are not how they should be. It raises a whole other area that evaluators don't look at and that has to do with the power of spirituality or the power of thinking, and that also can assist in healing.

Ross F. Conner, PhD
University of California, Irvine

If you have the usual evaluator coming in to see your mother's infected foot, you focus on Western medical treatment only. You've got to really understand the large picture there before you can understand what might be possible causation for that infection, and what may be effective for treatment.

Paula M. Lantz, PhD
University of Michigan School of Public Health

I have a little story related to that, too. Earlier this summer, I was in Anchorage working on an evaluation project for a program serving Alaska Native women. One thing we wanted to better understand was: What are the cultural beliefs that these women have around cancer? It was a cancer screening program. We were told, "You can go in and ask even the nurses and some of the community health aides about these cultural beliefs, but they're not going to

want to tell you because they have the beliefs themselves and when you talk about them, you give them power. When you say these things out loud, you're going to give the cancer more power. There are things that people don't talk about. So, as an outside evaluator coming into a community, you can't just say, "Oh, we have to be culturally sensitive and collect information on some of the stuff." You're not going to get it.

Ross F. Conner, PhD
University of California, Irvine

I experienced something similar. A Korean woman named Wendy started a cancer-screening program in her community. She got some money, and started doing some mammograms for Korean women. Word got around that Wendy was spreading cancer among Korean women. This lady with her x-ray machine was viewed as a spreader of cancer among those women. Wendy stuck at it and now things have changed, but this is an example where the cultural beliefs were a barrier to effective screening.

Hank Balderrama, BSW, MS
Washington Department of Social and Health Services

I think an important issue is to legitimize the work that takes place in communities, because that work hasn't been done in the same framework. If you have somebody that is a folk healer, it doesn't matter which sub-culture it may be or which ethnic group, they have longer historic practices that work for their communities as part of that community's belief system. And that makes them no less legitimate in those communities than if you go to a hospital. But, if you go to one of those folks and somebody finds out about it, the person who is the folk healer may now have legal troubles, because the larger society doesn't recognize them as legitimate.

This was several years ago. There was an African-American professor who taught me about a situation where he was consultant to a young social worker in a hospital. The patient was an older African-American gentleman who had been there for a while, and the hospital staff couldn't figure out what was going on with him. So, the professor talked with the guy and it turned out that this guy was a kind of sick that the doctors in the hospital weren't going to be able to fix. He needed a root doctor. The social worker talked to the family and the patient and found this out. The next step was to find a root doctor, and then to bring the root doctor in, and the final step was to keep all of the medical staff away from there, so that the root doctor could do what the root doctor needed to do. The medical staff couldn't be there, overly skeptical, interfering in that process. Well, it worked, and within a couple of days, the guy was ready for discharge.

So, the lesson behind all of that is to understand what the man needed, coming from his frame of reference. I raised my hand after the professor had finished his case study, and I said, "How did you tell them to document that?" They were in the hospital, treating the patient and they needed to document what they were doing. The documentation of that intervention is no less legitimate than what the rest of the doctors there and the medical staff did, which wasn't working. Yet, just like the ant story, we hesitate to tell that in public because people won't understand. When we don't, it doesn't legitimize that

which we do, so it's kind of "Damned if you do and damned if you don't."

Emma V. Sanchez, BA, BS, MPH
Harvard University

For me, the stories uncover the complexities that are involved in evaluation with diverse communities. I have a fear of legitimizing cultural forms that actually don't produce health and well-being. I don't think that all cultures are perfect and that all the cultural habits will be great. I think that is the risk that we might be taking.

Doug Easterling, PhD
University of North Carolina at Greensboro

One thing that the stories do is to expose that evaluator culture as culture. Each has biases and limitations. If the evaluation culture becomes one of many, as opposed to the one that gets superimposed on local culture, that brings up other problems. I see a lot of power in the stories, in terms of lessons for evaluators and funders. Most important is being sensitive and thinking differently about health and what health is.

Pauline E. Brooks, PhD
The California Endowment

I would be tempted, if I were working in Christine's culture, to get clarity on: "What are those boundaries where you feel that you do have power to influence your health?" Whether you have power to move those ants or not, and you're bringing something on yourself, as opposed to something that just comes into your life that you don't have control over, say diabetes. I think those boundaries are places where cultures can grow. Those are possible learning places, where different cultures can meet one another, where new ideas can be introduced. In our evaluation boundaries, we don't deal with spirituality. We talk about health. We don't deal with mental health. We don't deal with things we can't see, touch, or measure. Those are boundaries that we have, a different kind of boundary, but one the mainstream society placed on ourselves.

Hank Balderrama
Washington Department of Social and Services

The thread in there is the need to individualize the evaluation in your community interventions according to the beliefs and the practices of the community, whether it is an African-American community in Detroit, or a Native American community in the Southwest. You still need to tailor what you do to those people, and you have to understand that within those groups there are going to be people who are very traditional in one aspect, and people who are much less traditional, and probably a whole lot more that are in the middle. So the object of all of this is the storyline, and the thread is individualizing your interventions and your evaluations.

Christine Lowery, PhD

University of Wisconsin at Milwaukee

I think these are illustrations. Stories are really for understanding. It is really to help you understand that there are other things that you have to consider. Stories start that thinking process, and they challenge your old ways of thinking, and that is their purpose.

Quinton Baker
Community Health, Leadership and Development

One of the crucial things the stories reinforce is the importance of knowing the culture. You need to spend time in the community. You have to be in that culture in order to have any intervention or evaluate the success of anything.
You can't do a cursory look. You can't make assumptions of what the culture is. If the stories do nothing else, they reinforce the need to clearly understand the community in which you are trying to evaluate.

Christine Lowery, PhD

University of Wisconsin at Milwaukee

I want to introduce another principle. This has to do with level of expertise and what experts are and what they are not. People shape things together and everybody brings a certain amount of knowledge. That is the idea behind the cbo, coalitions. From a Native perspective, there is this understanding of shared power and it really is the same concept of people coming together, but they bring their own body of knowledge to the table. It is the integration of that knowledge that becomes the shared power.

I think that is one of the basic principles. This whole idea, that professional evaluators are the experts, needs to change. We have to acknowledge that we are shaping the evaluation through a shared power process because we don't know the answers. We should acknowledge the reality of the community, the resources they bring to the table, their knowledge of their own culture, and their world-view. We can bring this together with the world-view and the culture of the evaluator, through share power.

Health Disparities And The Impact Of Poverty, Race And Ethnicity

Terence L. Jones, PhD
University of New Mexico

While the United States economy is generating unprecedented wealth, not all-racial and ethnic groups are sharing in this economic growth and well-being. People of color are being left behind in terms of pay, benefits and even health, according to a recent survey by the Institute of Health Policy Studies at the University of California, San Francisco (1). In the long term, this type of inequality assures a continued and growing job and income gap, which is dangerous for the burgeoning United States economy.

It is virtually impossible to have a frank discussion of inequality, nor devote an entire publication to evaluating community health programs, without confronting racism.

The fact that low income children and families fare worse, in general, than their higher income counterparts is well documented (2). However, a growing number of academics and policy advocates point to an expanding body of evidence demonstrating how racial and social inequities plague the health, justice and other social systems in the United States.

Social inequality has historically been characterized both by income differences and group oppression (3). Stigmatization has been one important aspect of systemic oppression. It transcends income, and includes religion, language, and national origin. In America, racism has been instrumental in meting out-group oppression that coincides with the country's origins. The genocide and enslavement of Africans began with the *Maafa* or Middle Passage as it is typically known in United States history books: the decades of forced transport of Africans to America to then be sold into slavery. Subsequently, generations of African offspring born into chattel slavery and subjected to racial oppression, have, for all intents and purposes, kept these African Americans in limbo and unable to move significantly beyond the glass ceiling of the social pyramids' lowest echelon.

It is virtually impossible to have a frank discussion of inequality, nor devote an entire publication to evaluating community health programs, without confronting the continuing blight of racism head on. The elimination of health disparities is a major focus of current urban health initiatives such as the Centers for Disease Control and Prevention funded CENTERED Project. The rates of excess mortality among African Americans and other peoples of color has a sobering effect on public health practitioners, policy makers and concerned community members throughout large urban centers in the United States.
Geronimus reported that only one of three 15-year-old males in Harlem and two of three similarly aged females could expect to live through middle age (4). This statistical information resonates a need for collaboration, both public and private, to improve health. Furthermore, Geronimus casts serious doubt on the impact of identification and modification of individual behaviors designed to increase life expectancies in disadvantaged communities (5). Instead, these seemingly omnipotent and ever increasing health disparities are cemented in basic social structure inequities, which are interwoven with the fabric of racism that continues to influence all aspects of life in America.

Other groups who have historically been affected by the stigma of inequality and racism include Native Americans who were slaughtered and forced onto reservations; Hispanics who had land taken and treaties ignored; and Asians who were placed in concentration camps. Incredibly, all of these same people, while being vilified and murdered in the workplace, helped fuel the United States' economic engine.

Institutional Racism. Simply put, it is "the use of institutional power to deny or grant people and groups of people rights, respect, representation, and resources based on their skin color. (Prejudice plus organized power. Rules, values, structures, practices, and processes, inculcated with generalized bias and prejudices that value and support one culture, race, or ethnicity over others)"(6).

While most urban health studies account for race, few analyze the impact of racism. The specter of institutional racism looms over all organizations in the United States, including the essentially humanitarian interests of the health care industry. "Health care" may be a misnomer, because the true focus of the system primarily involves the financing of medical care (7). Very little attention or investment has been directed toward the environmental, social, economic, or behavioral factors that affect health and well-being, or to the community-based strategies that are needed to address these factors (8). The rub occurs because government pays the vast majority of the United States' health expenditure each year. These are tax dollars generated by working people, so any suggestions of racial bias are highly disturbing.

Lancet reported in the January 2, 2000, issue that approximately 14% of the US population is African American, however, less than 3% of the physicians in the US are African American (9). The author reported that this discrepancy "is largely the result of centuries of institutionally enforced racial apartheid in one form or another." The mass media's role influences public perceptions of order and justice in society (10). Perpetrators of crime portrayed in the news represent "evil forces" which need to be controlled in order to maintain social order (11). If the perpetrators of crime on television are largely people of color, and the guardians of law usually white, then viewers may come to the conclusion that people of color are evil-doers and therefore deserve less.

The color of a patient and their doctor should not be an issue when one arrives at the doctor's office for an appointment. However, most people of color would likely agree that having a physician who understands your culture is very important and can make a difference in overall health outcome. There is a suggestion in this type of response that cultural sensitivity is important and that certain community residents sense a disconnect with the health care system. Research in Menlo Park, California, by the Kaiser Family Foundation, in October 1999 found 51% of African Americans felt they were treated fairly most or all of the time by health professionals as compared to 71% of whites (12).

Similarly in 1990, the American Medical Association's Council on Ethics and Judicial Affairs concluded that African Americans were less likely than whites to receive certain

treatments (13). These differences in treatment prompted research reported in the February 25, 2000, issue of the *New England Journal of Medicine.* The survey of doctors showed videotapes of actors as patients presenting with chest pains. The patients were white and black, male or female. Blacks and women were less likely to be offered cardiac catherization than whites and men. For whatever reason, this finding was independent of other explanatory factors and is as close to a definition of institutional racism as doctors and health care providers may want to have noted (14). Unfortunately, these attributions do not cease with adult people of color. According to a report in the September 2000 issue of the *American Journal of Public Health*, African American and Hispanic babies are 70% less likely than Caucasian infants to receive complete well-child care. This disparity between minorities and European Americans is not diminished even by better socioeconomic conditions (15).

For public health to succeed, it must be re-crafted in a framework that locates organized and active communities at the center as initiators and managers of their own health. Political measures are necessary to narrow the abysmal gap in health disparities. Movements of organized labor, women, African Americans and others, separately and together, have won improvements through the strength of united action. (16)

There are only two states in America where the majority of the populations are people of color: Hawaii and New Mexico (17). In New Mexico, the 1990 Census Public Use Microdata Sample shows that poverty is more prevalent in the rural population than the urban portions of the state. The data show that more than 27% of the rural, as opposed to 18% of the urban, population reported living below the poverty threshold. Native Americans were the poorest racial group in the state, with a poverty rate of 47% (18). Nationally, in 1996, Native Americans had a poverty rate of 54%, African Americans 49%, Hispanics 61%, Asian Americans 29% and White Non-Hispanic 26%, according to the National Survey of America's Families.

Poverty And Health

The association between health and poverty (or, more broadly defined, socioeconomic position) is among the most robust findings of social epidemiology (19).
It is important to recognize that the factors, social and psychosocial, most closely associated with morbidity and mortality in the United States have an even more pronounced effect on those who are poverty stricken in society. Examples include material hardships; psychosocial conditions of acute and chronic stress or of overburdened or disrupted social supports; and toxic environmental exposures (20). As Link et al. pointed out, those of a lower socioeconomic position also have less ability than others to gain access to information, services, or technologies that could protect them from or ameliorate risks (21). Further, there appears to be a "dose-response" relationship: long-term poverty is more devastating to health than short poverty spells, both for children and adults. For impoverished African Americans, excess morbidity and

mortality increase over the young and middle adult years, which suggests the cumulative health impact of persistent disadvantage (22,23).

As poverty radiates in downtown urban hubs, it has become the catalyst in the reaction with characteristics of the urban environment to produce a particularly lethal dose. Potential contributors to this dynamic include a lack of adequate housing in the urban arena. Increased housing prices have been a formidable problem for those already suffering, because their meager incomes have failed to keep pace. Remarkably, rather modest amounts of housing assistance have been shown to play a vital role in increasing one's employability. Equally important is whether housing developers will continue to have a keen interest in providing quality, affordable housing for those who are often underserved. More families have lost their Housing and Urban Development subsidized housing, or risk losing it, because landlords are dropping out of the federal program known as "Section 8" to seek higher rents on the open market.

Neighborhood conditions invariably have some effect on access to education and jobs. Also contributing is the transition from a manufacturing-based economy to a service-oriented one (24). This restructuring resulted in extremely high rates of unemployment coupled with the loss of well paying, unionized jobs. These service sector jobs are characterized by little or no health or retirement benefits. Meanwhile, the urban poor have confronted new challenges in gaining access to medical care (25).

There appears to be a strong correlation between poverty and property deterioration. The two are part and parcel of the causes of early health problems and excess mortality in low-income communities. To begin to mitigate these ailments there is an obvious need for improved, affordable housing. Homeownership is the best way to accumulate wealth and build strong, vital neighborhoods. In addition, jobs are needed with wages that can sustain and assist a family to rise above the poverty threshold. Most importantly, communities and policymakers must understand the role of race in allowing deterioration of the nations' housing stock.

Discriminatory Public Policies

In order to comprehend the role of race and ethnicity in understanding poverty and urban health, one must look at the role of social relationships that have been institutionalized over time between the majority and "minority" populations (26). These relationships privilege the majority population and contribute to the poverty that is associated with race (27). The "minority" population, lacking power and privilege, includes an underclass that suffers disproportionately adverse health consequences. These symptoms occur in inner city neighborhoods that exist side by side with urban villages rich in social-connectedness and mutual cooperation. This coexistence belies the historical development of these cultures in the current urban environment.

The development of the current urban environment was influenced by race conscious policies. Prior to World War 2, there was a conduit established between the northern and southern United States. An exodus of African Americans headed north, initially in response to increased demand for labor to sustain the war effort. In northern urban

destinations, European immigrant neighborhood groups, government officials, and developers worked to avoid integration of African Americans with established immigrant neighborhoods. This produced the outlines of today's urban black ghettoes (28). Highway construction and public housing projects isolated black neighborhoods from other areas, while other policies prevented blacks from moving to emerging suburbs. Following World War 2, African Americans were effectively frozen out of the suburbs by racial covenants, discriminatory mortgage practices, and racial steering. In contrast, whites were offered low-cost homes in the suburbs and low interest rates on government subsidized home mortgages, and benefited from publicly funded transportation projects that linked their suburban homes to employment and cultural centers.

Such housing and transportation policies promoted segregation and prevented many African Americans from escaping poverty, as urban centers lost jobs (first as industry moved to the suburbs and later because of macroeconomic restructuring away from industrialized jobs). They also precluded blacks from enjoying the accumulation of wealth associated with the vast appreciation of suburban housing values (29). Meanwhile, there has been little sustained investment, public or private, in central city areas. Race has been an explicit factor in this circumstance (30).

Stereotypes

Negative stereotypic judgements of African Americans affect the treatment decisions of health providers (31), and influence the hiring practices of potential employers (32). Thus, it is critical that public health programs understand the factors that shape public sentiment on race and determine how these factors might be influenced. Anti-black attitudes were described by Staples (33). He realized that he was perceived as frightening, particularly to Caucasians, merely because he was an African American. In particular, research on perceptions of and emotional reactions to crime suggests that Caucasian Americans are particularly likely to associate violent crime with people of color (and particularly African Americans) as opposed to Caucasians (34).

Clearly, the stereotyping of African Americans and crime has a long history and is a reflection of many variables. However, most individuals report that the media serve as their primary source of crime information (35). Entmann noted a greater frequency of African American criminal suspects than Caucasian criminal suspects, who were portrayed as "nameless" or unidentified in newscasts, a characteristic of news images that he feels may encourage stereotyping (36).

Consequently, future researchers must turn their attention to the effects of existing racial portrayals and to explore new ways of news reporting about crime that may help to combat destructive stereotyping of African Americans as "dangerous criminals."

Implications

To improve health and prevent disease, as illustrated in Healthy People 2010, the United States must do more to explain health disparities and research socioeconomic interventions (37). The nation's inability to achieve more than 15% of the goals

identified in Healthy People 2000 (38) stems in part from the disproportionate burden of certain health problems in urban areas (36). Although rural areas also experience higher than average morbidity and mortality that demand attention, in the last 50 years, the excess mortality and morbidity experienced by the poor and people of color have become increasingly concentrated in cities (39).

The lack of a political agenda for improving social conditions in cities stems from several related phenomena including the shift of political power to suburban regions, where elected officials focused on policies that favored these areas at the expense of cities. At the same time, the national government lost power to the states and multinational corporations. In addition, the public health community has failed to define a research agenda for urban health.

Policies that affect urban poverty influence fundamental causes of health inequality. Policies that are likely to erode income, housing or neighborhood conditions; fragment or impose new obligations on already overburdened networks; or proliferate demeaning and demoralizing stereotypes, affect the material and psychosocial conditions of life for the urban poor and thus their health (40).

Notes

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A Letter From The Community

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When we partnered with a community-based organization to apply for a Racial and Ethnic Approaches to Community Health (REACH) grant last year, we asked participants and residents to submit personal letters of support. We asked them to express in their own words how this grant funding would impact on their health status and life. Here is an excerpt from one of those letters written by a fifty-one year old Black woman who lives in a small, rural town located in Eastern Arkansas that has a majority Black population.

I was hesitant about writing this letter, but the following passage from your request, ***"The President has committed the nation to an ambitious goal by the year 2010 to eliminate disparities in health status experienced by racial and ethnic minority populations in key areas while continuing the progress we have achieved in improving the overall health of the American people,"*** *burned into my every thought and gave me the incentive to write this letter.*

I remember the day over twenty-five years ago when my mother was diagnosed with 'sugar.' She stated that she has many relatives and friends who have been diagnosed with diabetes: Two brothers, co-workers, neighbors, and a daughter. She shares the same belief as most of the people in her town: when people my age and older talk about their high blood pressure and 'sugar,' I think treatment; and when the younger staff is diagnosed, I think prevention and become gravely concerned.

As writing this letter continues to provoke thought, I can remember people talking about having to transport their loved ones to the doctors (some did not have transportation of their own, therefore, they had to access it). I can now recall people taking time off work, flexing their time, or missing work to access medical care. I now know that they did not understand all the aspects of these diseases.

In everyday life, I am a wife, mother, sister, neighbor, community organizer, and advocate. Today, I am petitioning you to help us to help ourselves. There must be a process that will help us to eliminate some of the pain these diseases are causing the ***Black Families*** *in my community. I am prayerful that it will not take* ***another twenty-seven years.***

Striving to make a positive difference,
Mrs. S.